Health Care for Health care Workers
Meeting Minutes
Thursday, March 20, 2008

Attendees:
Kris Carlson, Lorna Palin, Dawna Brinkel, Mike Hanshew, Bruce Kramer, Katie Spaid, Kate Hurley, Bret Tate, Peter Butler, Jan Paulsen, Tom Osburn, roxann Settera, Ted Dick, Allicyn Wilde, Terry Flamand, Judy Maynard, Hope Heavyrunner, Christina Goe, Beth Anderson, Kelly Reynolds, Abby Hulme, James Driggers, Kelly Williams.

Welcome and Introductions

The group requested that a timeline be developed for the implementation of the health care project. This will be addressed at the April meeting.

Managed Care Options
New West came and presented information on managed care options in health insurance. New West began as an HMO/managed care plan provider. A majority of their enrollment is in the managed care plan. The New West offers managed care plans that are very similar in terms in relation to the benchmarks drafted by the group. The variability in plans comes in deductibles and co-pays, which help the buyer find price points that they can afford. One key feature of managed care plans is that they are very strict about which doctors you can see. Managed care plans steer the insured towards specific providers, provide network adequacy in a service area, and this provides savings. The trade-off is accepting a narrower network of providers for cost savings.

There are a few areas of the state without a coverage area and network adequacy, thus managed care might not be the best option for certain agencies, depending where they have workers. People can only be covered if they live or work within a 30 mile radius for network adequacy. With managed care plans the benefits kick in with co-payments without having to satisfy the deductible. There is a standard prior authorization for some services. The co-payment gets you in the door; however any lab, x-ray, etc. apply to deductible and co-insurance. This encourages people to go to the doctor, especially with regards to preventive care and encourages utilization.

Health Insurance Benchmarks
A handout was provided with a proposed draft of health insurance benchmarks that would need to be met for agencies to receive Medicaid funds to pay for health insurance. A discussion followed and the handout was updated based on group feedback (see website).

Discussion points included:

- Preventive coverage- should there be a separate cap written in the plan with a dollar amount or a limit of two office visits?

- Enrollment- The premium is usually paid in the prior month and coverage is effective on the first of the following month. Agencies feel they will need to have 90 days to shop for insurance in order to implement on January 1. Health applications are required for many agencies to receive coverage and they need to have at least 60 days to complete these prior to enrollment.

- Prescription Drug- should the deductible be separate from the large plan? The draft was updated with simplified the prescription coverage benefits.

- Dental Plan- should this be required coverage?

Abby will update the draft benchmarks and put them on the website. The group was encouraged to take the benchmarks and begin looking into the feasibility of providing coverage to their workings within the framework of the proposed benchmarks. The group will get together in April to discuss what they find.

Eligibility and Classification
Every employer will establish their own eligibility criteria. If an employer grows their business of eligible employees they must keep in mind that coverage is required even though the Medicaid funding won't cover the additional workers since the funding for this program is finite. Small group employers with 2-50 workers will have to offer health insurance for workers with 30 hours and over to comply with state law. Agencies with more than 50 workers will need to draw discretionary lines for eligibility very carefully with a plan advisor and get professional advice.

The group also discussed the inconsistent nature of the workforce and the number of hours per month a worker works and the effect of this on the agency ability to provide health insurance and meet the Department's standards. There was concern that this would pose a challenge to providing consistent coverage.

At the next meeting follow-up discussion and information will be provided on issues of eligibility and classification.

125 Premium Only Plan
Section 125 of IRS code allow employers and employees to pay for health cost without being subject to tax. Also, the employer doesn't have to pay the matching Medicare and Social Security on every dollar that the employer is paid in wages, which saves 20-30% for the employee. For example, if the cost for health coverage an employee pays is $25, the actual out-of-pocket cost to the employee is $20 with pre-tax savings. The savings for the employer is 7.65%, the current amount of Social Security and Medicare costs.

At Allegiance it costs a one-time fee of $250 to set up this type of plan and $100/year which is optional to provide updates to the plan. If you get audited by the IRS you would need a plan document, which is what Allegiance provides. If agencies already have a full-flex plan they wouldn't need a separate plan for the 125 Premium Only Plan, rather it would be included in the full-flex plan.

Distribution Methodology
A handout was distributed that outlined the estimated amount of funding and expected number of workers insured by agency. Agencies were encouraged to begin exploring how they would establish their eligibility criteria and come back to the meeting in April with feedback.

The group discussed two possible distribution methods. The first would be monthly reimbursement to agencies. The second was a rate increase. Agencies were asked to consider the impact of the two distribution methods and provide follow-up feedback at the April meeting.

The next meeting is scheduled for April 17 from 1:00-4:30 in Helena at the Cogswell budiling.